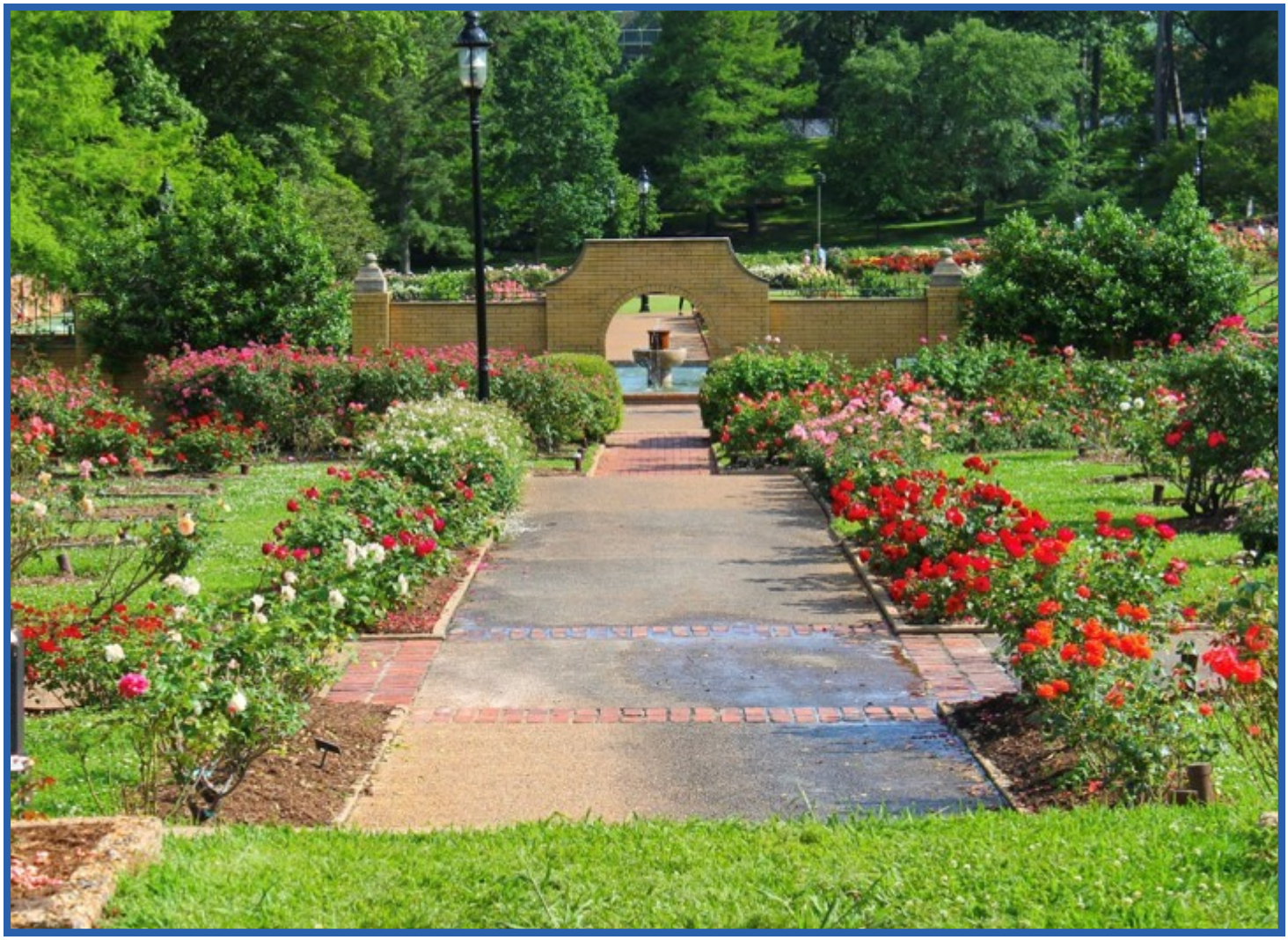
2021 **Employee Benefits Guide**

EFFECTIVE 01/01/2021 — 12/31/2021

CITY OF TYLER
A Natural Beauty



The information in this enrollment guide is intended to help you enroll in your 2021 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.

Photos by: Jimmy Ramsey

Table of Contents

Important Contacts

Coverage	Company	Phone Number	Website
Medical & Short Term Disability	HealthFirst TPA	866.219.1592	www.hfbenefits.com
Pharmacy Benefit Manager	CerpassRX	844.636.7506	www.cerpassrx.com
Telemedicine	Teladoc	800.835.2362	www.teladoc.com
Flexible Spending Account	Connect Your Care	877.292.4040	www.connectyourcare.com
Dental	Delta Dental	800.521.2651 Plan #18474	www.deltadentalins.com
Vision	Superior Vision	1.866.265.0517 1.888.494.1272 *(hearing aid discount)*	www.superiorvision.com
Life and Supplemental Life	Securian administered by Ochs	800.392.7295 (Customer Service) Plan #34638 888.658.0193 (Claims)	www.securian.com

You may contact Human Resources with any questions at:
903.531.1100 or at www.cityoftyler.org

Hours of Operation
Monday - Friday, 8 a.m. to 5 p.m.

Welcome

The City of Tyler is proud to provide you and your family with valuable and significant benefits. This Employee Benefits Guide was designed with you and your family in mind. This valuable reference guide, is an overview of the services and benefits available to you as an employee of the City of Tyler. Please take the time to carefully review the guide for any changes or updates. Inside you will find the information you need to make informed decisions regarding the selection and continued management of your benefits for the 2021 Plan Year.

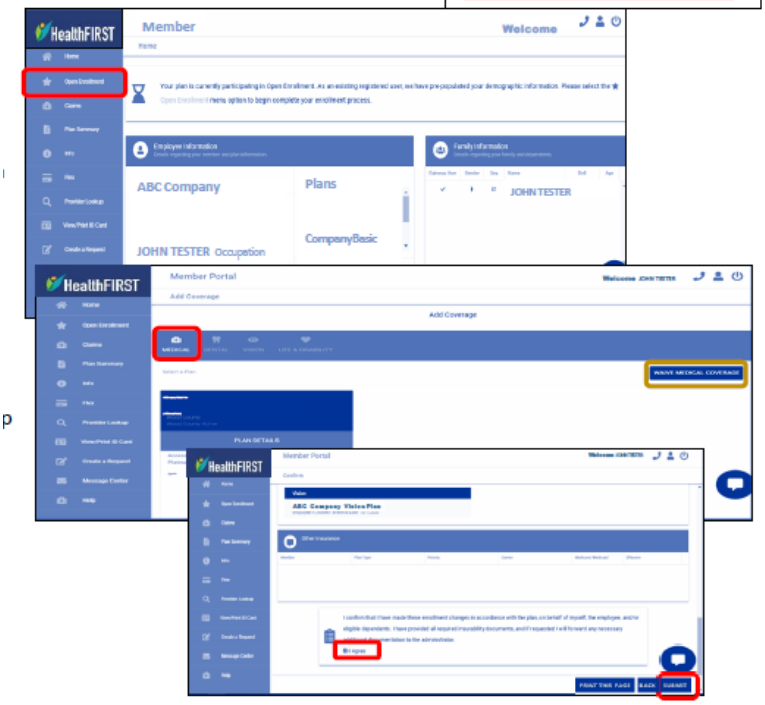
How to Enroll

***(Current Enrollees)* To Register:** Go to https://hfbenefits.vbagateway.com/

1. Select **Click Here to register and/or enroll** on the welcome screen.
2. From the dropdown, select **Member** for the portal.
3. Enter the last 4 digits of your SSN and birthdate.
4. Your Gateway Registration Code is your birthdate in MMDDYYYY format plus the last 4 digits of your SSN.
5. Create a username and password, enter your email address, and select **SUBMIT.**
6. You will receive an email confirming your registration that will contain a link for you to click on. This will open a popup window.
7. Select **CLICK HERE TO ACTIVATE**. A new popup will appear, select **Click here** to login.
8. When the login page appears, enter your username and password from Step 5 and **LOGIN**.

To Enroll or Change Benefits:

1. Your current information and elected plans will be displayed. Select **Open Enrollment** on the left sidebar.
2. Confirm information on next screen is correct. If not, **EDIT ENROLLMENT**. Select **NEXT**.
3. Select **ADD DEPENDENT**, if needed, and complete required fields. You will need SSN, DOB, and Address. Select **NEXT** when completed. If no dependents, select **NEXT**.
4. Review info. Select **EDIT ENROLLMENT** next to name to make changes. Select **NEXT**.
5. Select the Medical Plan you want to enroll in from the list or if you elect to waive coverage. Follow prompts to Select Plan and Coverage Level and **APPLY.** Repeat this step for each benefit coverage available. *If electing FSA and Short Term Disability, you will need to know the dollar amounts for both elections to complete the screens for these elections.*
6. After all elections are completed, select **NEXT**.
7. Review the Confirmation page for accuracy of info and elections. If corrections are needed, select the **BACK** button to get to the appropriate page to make changes. If information is correct, check the **I Agree** box and then **SUBMIT**. This page can also be printed for your records.



Open Enrollment starts November 2nd and runs through November 13th. The system will close November 13th at midnight.

Required Information	
Everyone	• Group Number: 0070053 • Corporate Code: 7005318 • Social Security Number for self & dependents
Add / Delete Spouse	• Marriage License • Divorce Decree
Adding Dependent	**<u>ONE</u> or more of the following:** • Birth Certificate • Qualified Child Support Order • Adoption Papers • Court Documentation for Foster Child • Proof of Income Tax Deduction

Eligibility

Who is Eligible?

If you are a full-time employee regularly scheduled to work 40 hours or more a week or a part-time employee scheduled to work 30 hours or more a week you are eligible to enroll in the benefit plans described in this Employee Benefit Guide.

If enrollment is not completed within 30 days, you will have no coverage for the remainder of the plan year for the following voluntary plans:

- Medical Plan for yourself or dependents;
- Dental Plan;
- Vision Plan;
- FSA-Health Account;
- FSA-Dependent Care Account;
- Supplemental Life Insurance Plan;
- Accidental Death & Dismemberment Plan; and
- Short Term Disability

Eligible employees are automatically enrolled in the basic term life and accidental death and dismemberment. Please note, you must designate your beneficiary for these plans upon your enrollment.

Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

Dependent children are eligible for insurance until age 26. Please keep in mind, you may be required to furnish evidence of dependency during random eligibility audits conducted by an outside consultant.

FAQs

When Does Coverage Begin?

The elections you make during Open Enrollment are effective January 1, 2021 - December 31, 2021.

New Hires: The waiting period is 90 days following the date of employment.

You are required to enroll no later than 30 days after your first day of regular, full-time or eligible part-time work with the City.

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

No, if you are not making any changes, you do not need to complete open enrollment.

If I want to decline coverage, must I still complete the Open Enrollment process?

Yes, only if you are currently enrolled. It is important that Human Resources has a record of your decision to cancel those coverages. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event. See "Qualifying Life Events Section" on **page 6**.

Can I Enroll My Spouse or Dependent on One Plan and Myself on Another?

No, all covered dependents, including spouse, must be on the same plan as the employee.

Can I Drop or Change Plans During the Plan Year?

No, changes can only be made if there has been a qualifying life event or personal life change. See "Qualifying Life Events Section" on **page 6.**

Things to Consider:

Take the following situations into account before you enroll:

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? Do you need to add or remove any dependent(s) and/or update your beneficiary designation? See Human Resources.
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria.

Helpful Tips and Reminders

- Take the time to carefully review the guide for any changes and updates. Choose the right coverage level, such as individual or family.
- Gather the correct information for your dependents such as social security numbers and birth dates.
- Make sure your address and personal information is current. If your information is not current you may miss out on important information such as insurance cards, plan documents, etc. Notify Human Resources if any of your information needs to be updated. You will need to fill out an address change form to update your address.
- Visit each vendor's website for additional information. Don't forget to review each provider directory. Make sure your physician is In-Network.

Qualifying Life Events

Due to IRS regulations, once you have made your choices for the 2021 Plan Year, you won't be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event. Benefits that can be changed include: Medical, Dental, Vision, Supplemental Life, Dependent Life or Voluntary Accidental Death and Dismemberment plans, or the Flexible Spending Account and Dependent Care Spending Accounts **only** if you have any of the life changes that affect your eligibility or coverage outlined below.

When one of the following events occurs, you have **30 days** from the date of the event to request changes to your coverage. **Any changes must be submitted to Human Resources for approval.**

- Change in your legal marital status (marriage, divorce, annulment, legal separation or death).
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent) or your dependent becomes eligible or loses eligibility for coverage due to age.
- Change in your dependent or spouse's employment status or your spouse's employer offers benefit plans with a different plan year that affects your coverage.
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage.
- You or your eligible dependent take or return from an unpaid leave of absence that affects coverage.
- Entitlement to Medicare or Medicaid (or loss of).
- Change in your address or location that may affect the coverage for which you are eligible.

Your change in coverage must be consistent with your change in status. The change must result in the gain/loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain/loss. Please direct questions regarding specific life events to Human Resources.

TIP: Having existing family coverage DOES NOT enroll the new dependent

In the case of a qualifying event allowing you to add or delete dependents from your coverage, that includes current coverage only. Changing plan types is not allowed under the Plan.

They are referred to as life changes, qualifying events, family status changes, IRS changes. Regardless of the terminology, your new election must be consistent with your status change. Consistent means the change must result in the gain or loss of coverage by you, your spouse, or any of your dependents and the new election must reflect that gain or loss. An employee with current coverage may add or delete dependents to or from that coverage.

Medical, Dental and Vision Plan

MEDICAL PLAN

	Employee Semi-Monthly Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS		
Employee Only	$30.42	$60.83
Employee +Spouse	$160.28	$320.56
Employee + Child(ren)**	$124.54	$249.08
Employee + Family	$217.18	$434.35

HealthFIRST

** Cost for up to 3 children - An additional premium of $15.15 semi-monthly or $30.30 per month will be added for each additional child over 3.

DENTAL PLAN

DELTA DENTAL®

	Employee Semi-Monthly Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS		
Employee Only	$4.91	$9.82
Employee +Spouse	$18.05	$36.10
Employee + Child(ren)	$17.48	$34.96
Employee + Family	$27.17	$54.34

VISION PLANS

	GOLD $150 BUY-UP PLAN 1		GOLD $100 BASE PLAN 2	
	Employee Semi-Monthly Contribution	Employee Monthly Contribution ($)	Employee Semi-Monthly Contribution	Employee Monthly Contribution ($)
CONTRIBUTIONS				
Employee Only	$3.07	$6.15	$2.75	$5.50
Employee +Spouse	$5.25	$10.50	$4.65	$9.30
Employee + Child(ren)	$5.57	$11.15	$4.95	$9.90
Employee + Family	$8.35	$16.70	$7.40	$14.80

SuperiorVision

Medical Benefits

HealthFIRST

Benefit By Type of Network

	AccessDirect Platinum Network (ADP) In-Network	Outside of ADP Service Area In-Network	Out-Of-Network
Maximum Benefit - *maximum dollar amount that your insurance company will pay out during your lifetime for non-essential healthcare services.*	Unlimited	Unlimited	Not Covered
Coinsurance - *the portion you pay of the share of the payment made against a claim.*	20%	30%	Not Covered
Individual Deductible - *The amount you pay for covered health care services before your insurance plan starts to pay.*	$1,000	$1,600	Not Covered
Family Deductible - *Coverage begins for the entire family, even those family members who haven't met their individual deductibles yet, as soon as the family deductible is met.*	$3,000	$4,800	Not Covered
Individual Out-of-Packet Maximum - *The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.*	$6,350	$6,350	Not Covered
Family Out-of-Pocket Maximum - *The maximum amount that an entire family unit on a health insurance plan will be responsible for.*	$12,700	$12,700	Not Covered
Physician Office Copay - *A fixed amount you pay for a covered health care service at a regular office visit after you've paid your deductible.*	$30 copay	30% after deductible	Not Covered
Specialist Office Copay - *A fixed amount you pay for a covered health care service at an office visit with a specialist after you've paid your deductible.*	$30 copay	30% after deductible	Not Covered
Preventive Care - *the care you receive to prevent illnesses or diseases.*	Covered at 100%	Covered at 100%	Not Covered
Emergency Room Copay- *A fixed amount you pay for an emergency room visit.*	$250 copay/visit True Emergency 20% coinsurance In-network NOT true Emergency	$250 copay/visit True Emergency 30% coinsurance In-network NOT true Emergency	$250 copay/visit True Emergency; Not Covered if NOT true Emergency
Urgent Care Copay - *A fixed amount you pay for a walk-in clinic visit focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit.*	$30 copay per visit	30% after deductible	Not Covered
Hospital Inpatient - *the portion you pay of the share of the payment made against a claim care of patients whose condition requires admission to hospital.*	20% after deductible*	30% after deductible*	Not Covered
Hospital Outpatient - *the portion you pay of the share of the payment made against a claim care of patients whose condition does not require admission to a hospital .*	20% after deductible	30% after deductible	Not Covered
Home Health Care - *services that can be given in your home for an illness or injury.*	20% after deductible	30% after deductible	Not Covered
Skilled Nursing Facility - *a health-care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care including especially the supervision of the care of every patient by a physician, the employment full-time of at least one registered nurse, the maintenance of records concerning the care and condition of every patient, the availability of nursing care 24 hours a day, and the presence of facilities for storing and dispensing drugs.*	20% after deductible*	30% after deductible*	Not Covered
Mental Illness/Substance Abuse Inpatient - *24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*	20% after deductible*	30% after deductible *	Not Covered
Mental Illness/Substance Abuse Outpatient - *includes services that are usually provided outside a hospital, like in these settings: A doctor's or other health care provider's office, hospital outpatient department, a community mental health center.*	$30 copay per visit	30% after deductible	Not Covered
Telemedicine - *Refers to the practice of caring for patients remotely when the provider and patient are not physically present with each other. Only covered through Teladoc.*	$0 copay when using Teladoc	$0 copay when using Teladoc	Not Covered

Note: Please refer to Summary Plan Description for a full outline of your medical coverage.
*Services must be pre-certified.

Prescription Drug Benefits

Prescription drug coverage provided by CerpassRX is included for employees enrolled the City's medical plan.

	30 Day Supply	90 Day Supply	Mail order
Specialty:	$125 copay	Not Covered	Not Covered
Non-Preferred Brand:	$100 copay	$250 copay	$300 copay
Preferred Brand:	$60 copay	$150 copay	$180 copay
Generic:	$15 copay	$37.50 copay	$45 copay

Note: Please refer to Summary Plan Description for a full outline of your prescription drug coverage.

The mobile app provides easy, on-the-go access to your personalized health information. Once you have your member ID number, download the app to take advantage of the benefits your pharmacy plan offers.

With the Mobile App in your Pocket:

- Stay on top of medication refills. See when refills are due, get refill reminders and quickly contact your pharmacy.
- Pull up your medication history anytime to show your doctor what medications you are taking.
- Learn about medication side effects and interactions.
- Find network pharmacies by ZIP code or location, then check and compare current prescription prices.
- Learn ways to save on your prescription by switching from brand name to generic or splitting a higher dosage pill.
- Track individual and family spend.

Managing your prescription medications is a key part of managing your health. Take your medication information with you wherever you are with the mobile app.

Access your private, secure member portal today. Visit www.cerpassrx.com - Member Portal

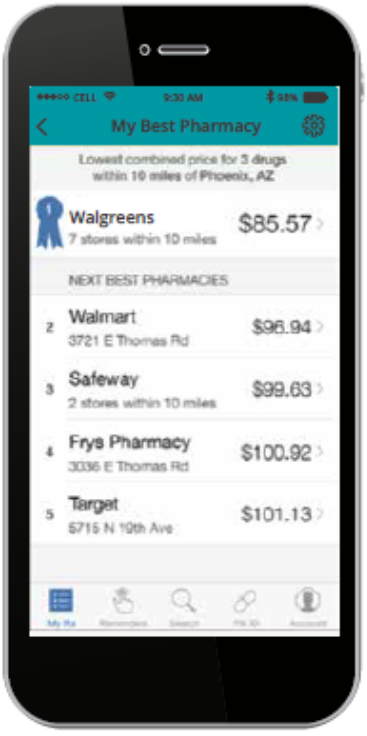
Member Portal

This private, secure website is designed just for you. Your pharmacy plan information is available and kept up-to-date in real time.

Easy Access Allows You To:

- **Manage all your prescriptions on a single dashboard**
- **Keep track of your health history**
- **Learn more about your prescription drugs**
- **Compare prices at local pharmacies**
- **Find your lowest prescription cost**
- **Transfer your prescription to a different pharmacy**
- **Locate your pharmacy and get driving directions**
- **Track your individual and family spend**
- **Take it all with you through the mobile app**

Get the app by searching for CerpassRx at the Apple App Store or Google Play.



HOW TO REGISTER

Visit http://www.cerpassrx.com/members-page/ and click on the member portal button. With your CerpassRx ID card handy, click"activate your account". From there, enter your member ID (as shown on your ID card) and proceed with completing your personal information to activate your account.

CERPASSRX®

Need Help? Just Call Us!

We are here to assist plan members day and night! We are available to our members 24 hours/day, 7 days/week. Please contact us at 844-636-7506 for any questions regarding your pharmacy benefits.

Find an In-Network Provider

AccessDirect Platinum Network (ADP)

- Step 1: Go to www.adppo.com.
- Step 2: Click "Find a Provider".
- Step 3: "Agree" to terms.
- Step 4: Enter 0070053 in the "please enter your group #" box, then click "next step".
- Step 5: Enter your Zip Code or City and check whether you are looking for a "facility" or "physician".
- Step 6: You can search for a physician by name or by specialty.
- Call Direct: 866.219.1592

Outside of ADP Service Area

- Step 1: Go to www.uhss.welcometouhc.com/find-a-doctor.
- Step 2: Click "United Healthcare Options PPO".
- Step 3: Make sure to "change location" to the location you are searching in.
- Step 4: You can search by doctor name, specialty, facility name, clinic name or medical group name physician by name or by specialty.
- Step 6: You can search for a physician by name or by specialty.

Accessing Claims and EOBs in the NEW HealthFirst Gateway Portal

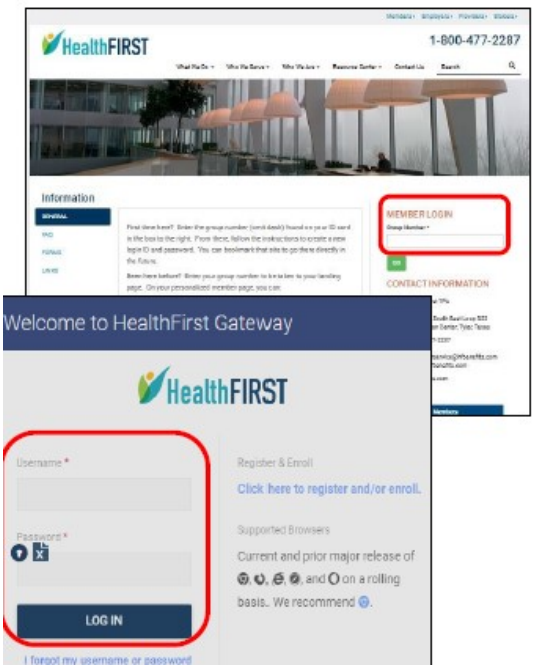
1. Go to hfbenefits.com and select MEMBER and enter Group Number 0070053 or go directly to www.hfbenefits/vbagateway.com.

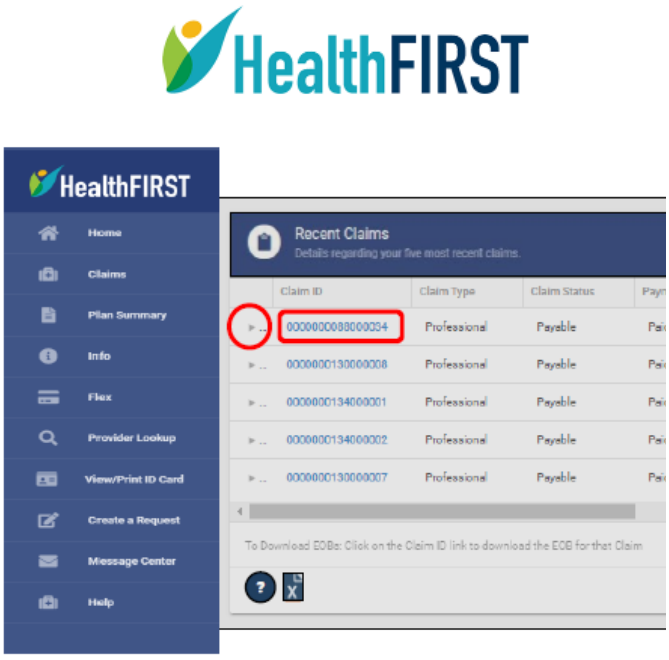
2. Enter your username and password created during open enrollment and select LOG IN.

3. On the Home screen, scroll down to the Recent Claims section which displays the five most recent claims with information about the claim. To display more detailed information about the claim, click on the arrow next to the Claim ID.

4. To view the EOB, click on the Claim ID number. This will open a screen with a message that your report is being generated. Click on the pdf icon in the bottom left corner to view/print the EOB.

5. If you need EOBs not displayed in the Recent Claims section, select Claims on the left sidebar. All claims that have been filed will appear in the CLAIMS section. Follow the same instructions in Step 4 to view more detail or to view the EOB.





Telemedicine - Teladoc

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.

It's an affordable option for quality medical care.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician

1. **Create account**

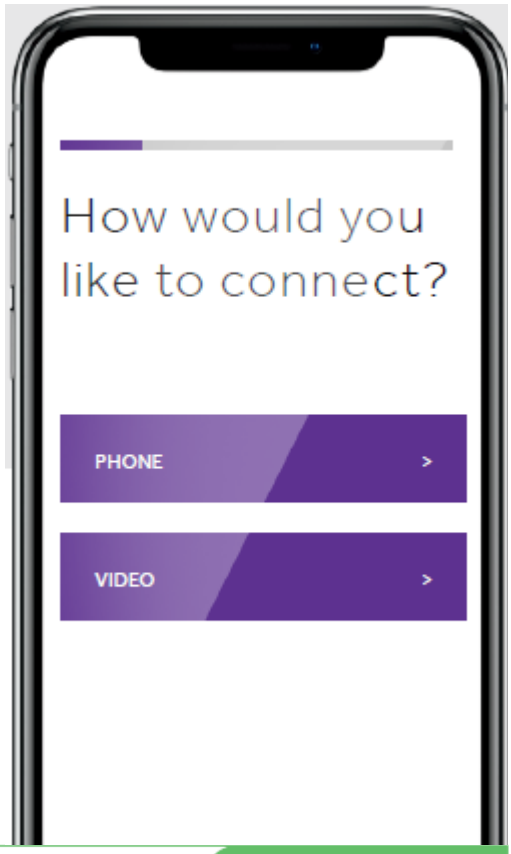
   Use your phone, the app, or our website to create an account and quickly complete your medical history.

2. **Request a visit**

   Use your device to request a visit and a Teladoc doctor will contact you at the requested time.

3. **Feel better**

   Your doctor will diagnose your symptoms and even prescribe medicine, if needed.



Talk to a doctor now

Teladoc.com | 1-800-TELADOC (835-2362)

Teladoc can treat

- Cold & flu symptoms
- Respiratory infection
- Sinus problems
- **And more!**

Use Teladoc when

- You need care now.
- You're considering the ER or urgent care for a non-emergency issue
- Traveling out of town

Teladoc's wait time

Talk to a doctor in minutes

Download the Mobile App!

Available on the iPhone App Store

ANDROID APP ON Google play

Dental Benefits

	Delta Dental PPO Plan
NETWORK	**DPO / Premier**
Deductible	$50 Individual $150 Family
Deductible Waived for Preventive	Yes
Diagnostic/Preventive	100%
Restorative/Basic	80%
Major	50%
Endodontics and Periodontics	Basic
Waiting Period	New Hires: 90 days
Calendar Year Maximum	$1,200
R&C Percentage	90%
Orthodontia Coverage	50%
Orthodontia Maximum	$1,000

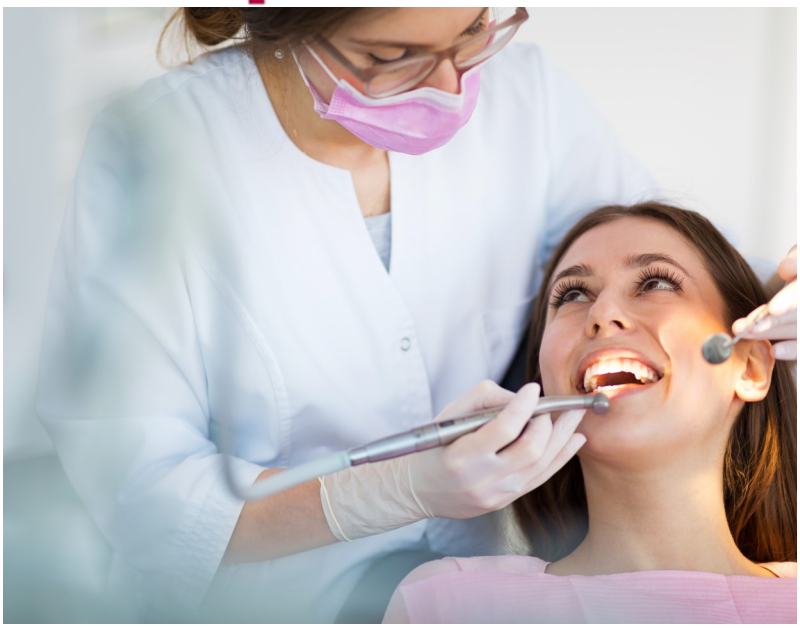
Additional Discounts:

Hearing Aid

- Discounts on hearing aids and one year of free follow-up care,
- 62% average savings off retail hearing aid pricing, with a best-price guarantee of 5%
- Call Amplifon at 888-779-1429

LASIK

- Discount on LASIK eye surgery, including pre- and post-operative visits
- 40-50% off national average price
- Call QualSight at 855-284-2020



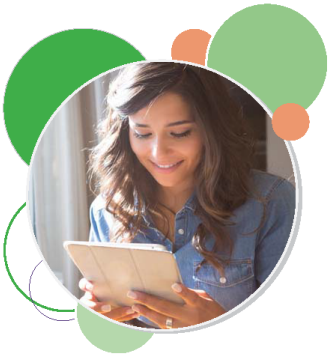
- ✓ Free to visit a dentist of your choice
- ✓ No balance bill if services provided in-network
- ✓ Must meet a Deductible—$50
- ✓ Maximum annual Benefit—$1,200
- ✓ Includes Child Orthodontic Benefits

Need to locate a network dentist or orthodontist?

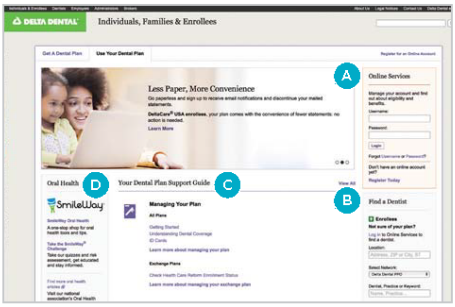
Log on to www.deltadentalins.com or Call customer service at 1-800-521-2651.

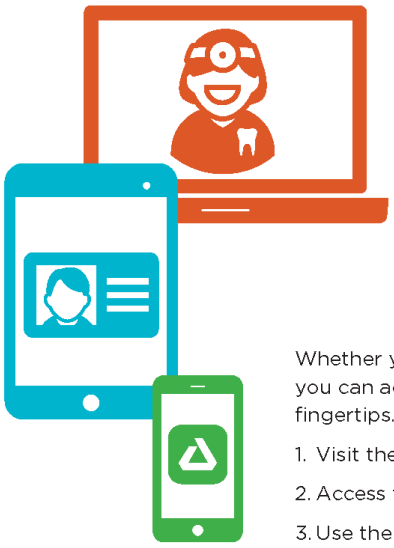
DELTA DENTAL

Stay Connected



Check the site





Want information about your dental plan? Take advantage of our web and mobile resources to:

- check your eligibility
- look up coverage details
- check claims
- find a network dentist
- improve your oral wellness
- and more

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit the **website**
2. Access the **mobile-optimized site**
3. Use the **free app**

1. Enter **deltadentalins.com/enrollees** on your computer's browser.
2. Browse the features listed below. If you haven't already done so, register for Online Services. Already got an account? Log in!

Features:

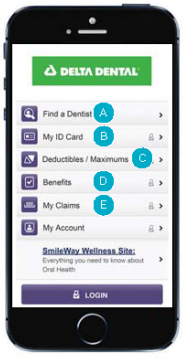
A. **Online Services** (register or log in): See benefits, eligibility, deductibles and maximums; check claims; view or print an ID card

B. **Find a dentist**

C. **Dental Plan Support Guide**

D. **SmileWay® Wellness site**

Go mobile[1]



1. Enter **deltadentalins.com** on your smartphone's browser.
2. Click the **Visit Mobile Site** button.

Features:

A. **Find a dentist**

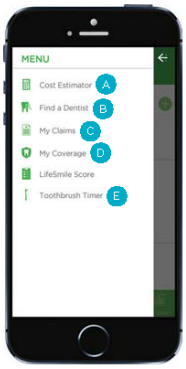
B. **View your electronic ID card**

C. **Check deductibles and maximums**

D. **See your benefits and eligibility**

E. **Check claims**

Get the app[2]



1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Features:

A. **Get a cost estimate**

B. **Find a dentist**

C. **Check claims**

D. **See your benefits, eligibility, deductibles and maximums**

E. **Use a musical timer to brush for 2 minutes**

¿Habla español?

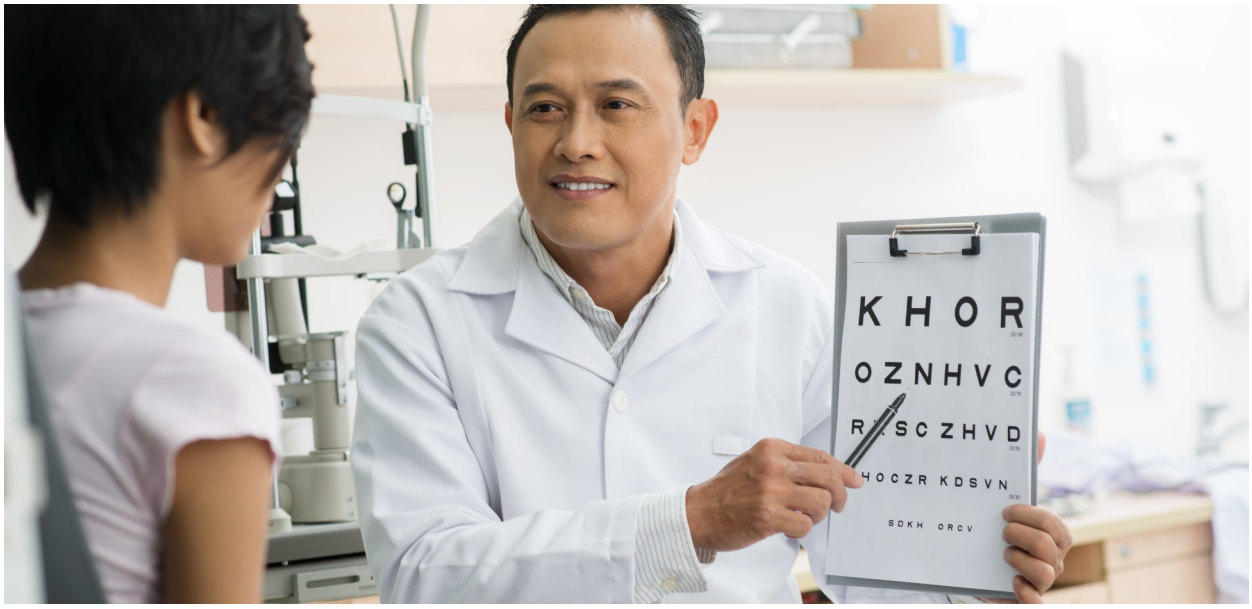
es.deltadentalins.com

We keep you smiling®
deltadentalins.com/enrollees

Vision Benefits

SuperiorVision

Vision coverage is provided through Superior Vision. The plan pays benefits for annual exams and corrective lenses. You pay a copayment for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you will receive greater benefits when you use in network providers.



	Gold $150 Buy Up Plan 1		Gold $100 Base Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
COPAY				
Exam (with dilation)	$10 copay	Up to $35 reimbursed	$10 copay	Up to $35 reimbursed
LENSES: STANDARD	Once every 12 months		Once every 12 months	
Single Vision	After $25 copay	Up to $25 reimbursed	After $25 copay	Up to $25 reimbursed
Bifocal	After $25 copay	Up to $40 reimbursed	After $25 copay	Up to $40 reimbursed
Trifocal	After $25 copay	Up to $45 reimbursed	After $25 copay	Up to $45 reimbursed
FRAMES	Once every 24 months		Once every 24 months	
Standard	Up to $150 Allowance after $25 copay + 20% discount	Up to $70 reimbursed	Up to $100 Allowance after $25 copay + 20% discount	Up to $70 reimbursed
CONTACTS	Once every 12 months		Once every 12 months	
Elective Contact Lenses	$150 allowance after $25 co-pay + 20% discount	Up to $80 reimbursed	$125 allowance after $25 co-pay + 20% discount	Up to $80 reimbursed
Medically Necessary	Covered in Full after $25 copay	Up to $150 reimbursed	Covered in Full after $25 copay	Up to $150 reimbursed
Laser Vision Correction	$200 Allowance		$200 Allowance	

***The frames & contact lens benefit is an either or benefit. For example, contact lens benefit in lieu of frames benefit.**
Note: Please refer to Certificate of Coverage for a full outline of your vision coverage.

New Partnerships with:

1-800 Contacts & Glasses.com

Basic Life

Paid for you by the City of Tyler

Benefits	Securian administered by Ochs Employee Coverage
Employee Life Amount - *Sum paid to beneficiary upon the insured's death*	$10,000
Employee AD&D Amount - *Benefits to the beneficiary if the cause of death is an accident*	$10,000
Accelerated Benefit - *Enables the policy holder to receive cash advances against the death benefit in the case of being diagnosed with a terminal illness*	24 months expectancy 100% to $1,000,000
Age Reduction Formula – *Amount life insurance starts reducing in face amount by percentage*	35% at age 65 50% at age 70 70% at age 75+
Line of Duty – *An additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.*	$10,000
Retiree Life Amount - *Sum paid to beneficiary upon the insured's death*	$5,000

Accidental Death and Dismemberment (AD&D) Insurance Coverage

If you are injured or die as a result of an accident, you or your beneficiary will receive a benefit based on the extent of the injury. AD&D pays benefits if death or dismemberment occurs within 365 days following the covered accident. AD&D insurance pays benefits in addition to any other benefits you receive under your life insurance coverage if you die as a result of an accident. The City of Tyler provides basic AD&D insurance coverage at no cost to you.

Voluntary Life & Accidental Death and Dismemberment for Employee and Dependents

Benefits	Securian administered by Ochs Employee Coverage
Employee Benefit - *Sum paid to beneficiary upon the insured's death*	$10,000 Increments
Employee Voluntary AD&D - *Benefits to the beneficiary if the cause of death is an accident*	Same as Life
Maximum Benefit - *maximum dollar amount your beneficiary can expect to receive*	$500,000
Guarantee Issue Amount - *benefit amount offered to an applicant regardless of health. Note: Newly eligible employees only.*	$250,000
Conversion - *option which allows the insured to switch to a different type of policy without submitting to a physical examination*	Included
Portability - *allows eligible insureds to continue their insurance coverage when they are in danger of losing that coverage because their employment is being voluntarily or involuntarily terminated*	Included
Accelerated Death Benefit - *enables the policy holder to receive cash advances against the death benefit in the case of being diagnosed with a terminal illness*	24 Months Expectancy 100% to $1,000,000
Waiver of Premium if disabled - *a clause that waives the policyholder's obligation to pay any further premiums should you become seriously ill or disabled*	9 Months Elimination To age 70
Age Reduction Formula - *amount life insurance starts reducing in face amount by percentages*	None
Line of Duty – *An additional amount of basic AD&D for public safety officers that suffer a loss while he or she is performing his or her customary duties for the City.*	Principal Sum up to $100,000

You may choose additional coverage for yourself, in $10,000 increments, up to $500,000. Premiums are paid on an after-tax basis, so any insurance benefits paid are not taxable when your beneficiary receives them.

Voluntary Life & Accidental Death and Dismemberment for Employee and Dependents Cont.

Benefits	Securian administered by Ochs Dependent Coverage
Spouse Benefit	$5,000 Increments
Spouse Voluntary AD&D	Same as Life
Spouse Maximum	Up to $250,000
Spouse Guarantee Issue	$50,000
Child Benefit	Choice of $5,000, $10,000, $15,000 or $20,000
Child Maximum and Guaranteed Issue	
Age Reduction Formula - *amount life insurance starts reducing in face amount by percentage*	None

securian FINANCIAL® | Ochs

HOW MUCH LIFE INSURANCE DO YOU NEED?

Check out the life insurance calculator at **LifeBenefits.com/Insuranceneeds**.

Insurance helps cover

- Funeral/burial costs
- Medical bills
- Taxes & living expenses (i.e. mortgage, childcare)

All Children Premium Table Monthly Rates (one premium insures all eligible children)			
$5,000	$10,000	$15,000	$20,000
$0.65	$1.30	$1.95	$2.60

Employee and Spouse Life & AD&D Insurance Monthly Rates

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate per $1,000	$0.08	$0.09	$0.11	$0.12	$0.15	$0.24	$0.40	$0.64	$0.78	$1.34	$2.09	$4.10
Coverage Amount												
$10,000	0.80	0.90	1.10	1.20	1.50	2.40	4.00	6.40	7.80	13.40	20.90	41.00
$20,000	1.60	1.80	2.20	2.40	3.00	4.80	8.00	12.80	15.60	26.80	41.80	82.00
$30,000	2.40	2.70	3.30	3.60	4.50	7.20	12.00	19.20	23.40	40.20	62.70	123.00
$40,000	3.20	3.60	4.40	4.80	6.00	9.60	16.00	25.60	31.20	53.60	83.60	164.00
$50,000	4.00	4.50	5.50	6.00	7.50	12.00	20.00	32.00	39.00	67.00	104.50	205.00
$60,000	4.80	5.40	6.60	7.20	9.00	14.40	24.00	38.40	46.80	80.40	125.40	246.00
$70,000	5.60	6.30	7.70	8.40	10.50	16.80	28.00	44.80	54.60	93.80	146.30	287.00
$80,000	6.40	7.20	8.80	9.60	12.00	19.20	32.00	51.20	62.40	107.20	167.20	328.00
$90,000	7.20	8.10	9.90	10.80	13.50	21.60	36.00	57.60	70.20	120.60	188.10	369.00
$100,000	8.00	9.00	11.00	12.00	15.00	24.00	40.00	64.00	78.00	134.00	209.00	410.00
$110,000	8.80	9.90	12.10	13.20	16.50	26.40	44.00	70.40	85.80	147.40	229.90	451.00
$120,000	9.60	10.80	13.20	14.40	18.00	28.80	48.00	76.80	93.60	160.80	250.80	492.00
$130,000	10.40	11.70	14.30	15.60	19.50	31.20	52.00	83.20	101.40	174.20	271.70	533.00
$140,000	11.20	12.60	15.40	16.80	21.00	33.60	56.00	89.60	109.20	187.60	292.60	574.00
$150,000	12.00	13.50	16.50	18.00	22.50	36.00	60.00	96.00	117.00	201.00	313.50	615.00
$160,000	12.80	14.40	17.60	19.20	24.00	38.40	64.00	102.40	124.80	214.40	334.40	656.00
$170,000	13.60	15.30	18.70	20.40	25.50	40.80	68.00	108.80	132.60	227.80	355.30	697.00
$180,000	14.40	16.20	19.80	21.60	27.00	43.20	72.00	115.20	140.40	241.20	376.20	738.00
$190,000	15.20	17.10	20.90	22.80	28.50	45.60	76.00	121.60	148.20	254.60	397.10	779.00
$200,000	16.00	18.00	22.00	24.00	30.00	48.00	80.00	128.00	156.00	268.00	418.00	820.00
$210,000	16.80	18.90	23.10	25.20	31.50	50.40	84.00	134.40	163.80	281.40	438.90	861.00
$220,000	17.60	19.80	24.20	26.40	33.00	52.80	88.00	140.80	171.60	294.80	459.80	902.00
$230,000	18.40	20.70	25.30	27.60	34.50	55.20	92.00	147.20	179.40	308.20	480.70	943.00
$240,000	19.20	21.60	26.40	28.80	36.00	57.60	96.00	153.60	187.20	321.60	501.60	984.00
$250,000	20.00	22.50	27.50	30.00	37.50	60.00	100.00	160.00	195.00	335.00	522.50	1,025.00
$260,000	20.80	23.40	28.60	31.20	39.00	62.40	104.00	166.40	202.80	348.40	543.40	1,066.00
$270,000	21.60	24.30	29.70	32.40	40.50	64.80	108.00	172.80	210.60	361.80	564.30	1,107.00
$280,000	22.40	25.20	30.80	33.60	42.00	67.20	112.00	179.20	218.40	375.20	585.20	1,148.00
$290,000	23.20	26.10	31.90	34.80	43.50	69.60	116.00	185.60	226.20	388.60	606.10	1,189.00
$300,000	24.00	27.00	33.00	36.00	45.00	72.00	120.00	192.00	234.00	402.00	627.00	1,230.00
$350,000	28.00	31.50	38.50	42.00	52.50	84.00	140.00	224.00	273.00	469.00	731.50	1,435.00
$400,000	32.00	36.00	44.00	48.00	60.00	96.00	160.00	256.00	312.00	536.00	836.00	1,640.00
$450,000	36.00	40.50	49.50	54.00	67.50	108.00	180.00	288.00	351.00	603.00	940.50	1,845.00
$500,000	40.00	45.00	55.00	60.00	75.00	120.00	200.00	320.00	390.00	670.00	1,045.00	2,050.00

Spouse rates are based off of employee age.

Short Term Disability Insurance Benefits

All active regular non-civil service full-time employees are eligible to participate in this plan at a cost of $15.00 per month.

Basic Monthly Earnings – *gross rate of pay used to determine benefit dollar amount*	Average monthly base salary or hourly pay before taxes. Does not include commissions, bonuses, overtime pay, or any other extra compensation.
Benefit Percentage - *percentage of your weekly salary*	60%
Maximum Weekly Benefit - *maximum dollar amount you can expect to receive*	$1,200
Elimination Period - *period of continuous disability which must be satisfied before you are eligible to receive short term disability benefit payments*	7th Day Sickness/7th Day Accident
Definition of Disability - *qualification for receiving the disability benefit*	Unable to perform all the material duties of your regular occupation, and unable to earn 80% or more of your covered earnings.
Maternity - *allows you to receive a portion of your pay if you are unable to work due to pregnancy/ maternity leave*	6 weeks – Normal Delivery 8 weeks - C-section
Benefit Duration - *length of time during which a benefit is paid*	Up to 26 weeks

To File a Disability Claim Contact Human Resources:

903-531-1100

HealthFIRST

Flexible Spending Account

Healthcare

–Employees are eligible to open a Flexible Spending Account (FSA) each year, which allows tax free payroll deductions for certain types of unreimbursed medical and/or dependent care expenses.

–**A maximum of $2,750 per calendar year may be contributed to your Healthcare FSA.**

–Accounts are pre-loaded with the annual election. You have access to all of your funds the first day of the new plan year.

– Up to $550 can be rolled over at the end of the year.

–Participants receive a debit card that can be used for medical expenses up to the amount of their annual election. You can also file a claim online for reimbursement.

Dependent Care Spending Account

–**A maximum of $5,000 per calendar year may be contributed to the dependent care account** ($2,500 if an employee's spouse also participates in a dependent care plan).

– You will be reimbursed for eligible claims up to the current contributed amount available in your account.

–***Money may not be transferred between medical and dependent care accounts.***

2021 FSA Maximum Contributions
$2,750

2021 Dependent Care Maximum Contributions
$5,000

Medical Care Flexible Spending Account Worksheet

Enter your annual out-of-pocket expenses for each of the following. Do not include any amounts for medical, dental or vision care premiums.

Health care $_____

Dental care $_____

Vision care $_____

Prescription drugs $_____

Total lines above $_____

Dependent Care Flexible Spending Account Worksheet

Weekly day care costs $_____

Total lines above $_____

Number of weeks you

Will incur expenses **X** _____

Multiply total by weeks $_____

(cannot exceed $5,000 per house hold)

Flexible Spending Account Cont.

FSA Eligible Expenses For a full list of eligible expenses please see IRS Publication 502.
Acupuncture
Chiropractor
Contact Lenses & Solutions*
Co-Payments
Dental Fees*
Medical Supplies
Glasses*
Hearing Devices
Lab Fees
Orthodontic Fees*
Prescriptions
Wheelchairs
X-Rays

*Also, Limited Care FSA eligible expenses

Non-Qualified FSA
Cosmetic Surgery/Procedures
Teeth Whitening
Marriage/Family Debt Counseling
Weight Loss Programs for General
General Health Items (vitamins,
Premiums

Note: If you terminate employment or experience a change in employment status from full-time to part-time, you are eligible to access FSA funds up to your termination or employment status change date. This means that any services after the previous mentioned dates are ineligible for reimbursement.

Dependent Care Eligible Expenses

Dependent care expenses incurred for services outside your home provided they are:

- incurred for the care of a qualifying person who is under the age of 13 when the care was provided

or

- incurred for the custodial care of your spouse or dependent who is physically or mentally unable to care for himself or herself. Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care

Nanny expenses, for services provided inside your home are eligible to the extent they are attributable to dependent care expenses and expenses of incidental

Employees (and your spouse if you are married) must have earned income during the year and you must pay for dependent care expenses so you can work or can look for work.

Payments must be made for a child and dependent care to someone you (or your spouse) cannot claim as a dependent. If you make payments to your child, he or she

Registration fees to a daycare facility are eligible as long as the fees are allocated to actual care and not described as materials or other fees.

Nursery school expenses are eligible even if the school also furnishes lunch and education services.

Food and incidental expenses (diapers, activities, etc.) may be eligible if part of dependent care charge.

Non-Qualified Dependent Care Expenses
Tuition fees for grades K-12
Meals*
Diapers*
Activity Fees
Late Fees
Overnight Camps
Sumer Camp Supplies

*Incidental fees are not eligible if broken out and billed separately by your provider.

Glossary

Allowed Fees: Term used by some dental plans for their participating dentist fees and / or maximum payable for a non-participating dentist.

Annual Deductible: The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985. This Act requires that continuation of group insurance be offered to covered persons who lose health, dental or vision coverage due to a qualifying life event as defined in the Act.

Coinsurance: The portion of covered health care costs for which the covered person is financially responsible, usually according to a fixed percentage. Co-insurance may be applied after a deductible requirement is met.

Copay: The charge you are required to pay for certain covered health services, such as a prescription or office visit.

Eligibility: Eligibility for benefits will begin following a 90 day waiting period after regular full-time employment hire date.

Explanation of Benefits (EOB): A summary of claims processed, which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement is available online. Some carriers mail them to your house, if requested.

Flexible Spending Accounts (FSAs): An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Health Care FSA and the Dependent Care FSA.

Guarantee Issue: The amount of coverage pre-approved by the Life Insurance Company regardless of health status.

Incurred Expense: An expense is considered incurred on the date services were rendered or supplies were received.

Initial Enrollment Period: The first 31 days of fulltime employment or 30 days from a covered life event.

In-Network / Out-of-Network: **In-network** providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates. **Out-of-network** providers are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum: The maximum amount of co-insurance you pay every year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at a percent of eligible charges during the rest of that year. Deductibles and copays apply to the out-of-pocket maximum.

Plan Year

January 1st through December 31st of each year

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to virtual visits.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	▪ Sudden numbness, weakness ▪ Uncontrolled bleeding; Severe cuts or burns ▪ Seizure or loss of consciousness ▪ Shortness of breath; Chest Pain ▪ Head injury/major trauma; Overdose ▪ Blurry or loss of vision	▪ Costs are highest ▪ No appointment needed ▪ Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	▪ Minor cuts, sprains, burns, rashes ▪ Fever and flu symptoms; headaches ▪ Chronic lower back pain; Joint Pain ▪ Minor respiratory symptoms ▪ Urinary tract infections	▪ Costs are lower than an ER visit ▪ No appointment needed ▪ Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications.	▪ General health issues ▪ Preventive services; Routine Checkups ▪ Immunizations and screenings	▪ May include coinsurance / deductible ▪ Appointment usually needed ▪ May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners/physician assistants. Treat minor not life threatening. Located in retail stores/ pharmacies, often open nights/weekends.	▪ Common cold/flu ▪ Rashes / skin conditions; Minor cuts / burns ▪ Sore throat, earache, sinus pain ▪ Pregnancy testing; Vaccinations	▪ Costs are same or lower than office visit ▪ No appointment needed ▪ Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or mobile app.	▪ Cold / flu symptoms such as a cough, fever / headaches ▪ Allergies; Sinus Infections; Family Health	▪ Cost is $0 copay through Teladoc. ▪ No appointment needed ▪ Immediate, private, and secure visits

GREATER

Cost & Time

LOWER

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

Required Notices

Women's Health and Cancer Rights Act: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Newborn's and Mother's Health Protection Act (NMHPA): Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA): The County of Galveston medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP): If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefit Security Administration, www.dol.gov/agencies/ebsa - 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services—www.cms.hhs.gov , 1-877-267-2323, menu Option 4, Ext. 61565

Your Prescription Drug Coverage and Medicare: Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Tyler and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **City of Tyler** has determined that the prescription drug coverage offered by the **City of Tyler** Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?** If you decide to join a Medicare drug plan, your current coverage with City of Tyler will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back. **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?** You should also know that if you drop or lose your current coverage with City of Tyler and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. **For More Information About This Notice Or Your Current Prescription Drug Coverage.** Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Tyler changes. You also may request a copy of this notice at any time. **For More Information About Your Options Under Medicare Prescription Drug Coverage.** More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Coverage After Termination (COBRA) - Health Coverage: You're getting this notice because you recently gained coverage under a group health plan **(City of Tyler Group Health Plan).** This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. **You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. **What is COBRA continuation coverage?** COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under

the Plan because of the following qualifying events: Your hours of employment are reduced, or Your employment ends for any reason other than your gross misconduct. If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: Your spouse dies; Your spouse's hours of employment are reduced; Your spouse's employment ends for any reason other than his or her gross misconduct; Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse. *Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:* The parent-employee dies; The parent-employee's hours of employment are reduced; The parent-employee's employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: The end of employment or reduction of hours of employment; Death of the employee; Commencement of a proceeding in bankruptcy with respect to the employer;; or The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Phone: 903-531-1112

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended: **Disability extension of 18-month period of COBRA continuation coverage:** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. **Second qualifying event extension of 18-month period of continuation coverage:** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **Are there other coverage options besides COBRA Continuation Coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**. **Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?** In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of: The month after your employment ends; or The month after group health plan coverage based on current employment ends. If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you. **If you have questions:** Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**. **Keep your Plan informed of address changes:** To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information: City of Tyler
212 N Bonner - Tyler, TX 75710- Phone: 903-531-1112

HIPAA) Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Your Rights: You have the right to: Get a copy of your health and claims records; Correct your health and claims records; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; and File a complaint if you believe your privacy rights have been violated.

Your Choices: You have some choices in the way that we use and share information as we: Answer coverage questions from your family and friends; Provide disaster relief; and Market our services and sell your information.

Our Uses and Disclosures: We may use and share your information as we: Help manage the health care treatment you receive; Run our organization; Pay for your health services; Administer your health plan; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests and work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **Get a copy of health and claims records:** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. **Ask us to correct health and claims records:** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. **Ask us to limit what we use or share:** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. **Get a copy of this privacy notice:** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. **File a complaint if you feel your rights are violated:** You can complain if you feel we have violated your rights by contacting us at 806.441.7122. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in payment for your care; Share information in a disaster relief

situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases we never share your information unless you give us written permission: Marketing purposes or Sale of your information.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways. **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.* **Run our organization:** We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.* **Pay for your health services:** We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.* **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.* **How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. **Help with public health and safety issues:** We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety **Do research:** We can use or share your information for health research. **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. **Respond to organ and tissue donation requests and work with a medical examiner or funeral director:** We can share health information about you with organ procurement organizations; We can share health information with a coroner, medical examiner, or funeral director when an individual dies. **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services. **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena. **Our Responsibilities:** We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. **For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. **Changes to the Terms of this Notice:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. **Effective Date:** 1/1/2021 **Privacy Contact: City of Tyler: 212 N Bonner - Tyler, TX 75710—**Phone: 903-531-1112

Health Insurance Marketplace Coverage Options and Your Health Coverage PART A: General Information: When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer. **What is the Health Insurance Marketplace?** The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2020 for coverage starting as early as January 1, 2021. **Can I Save Money on my Health Insurance Premiums in the Marketplace?** You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income. **Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?** Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.* Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. **How Can I Get More Information?** For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. *An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.* **PART B: Information About Health Coverage Offered by Your Employer:** This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer:

Eligible employees are Full time employees who work 30 hours per week and have completed the newly eligible 30 day waiting period. Coverage begins the first day of the month following the first 90 days of employment.

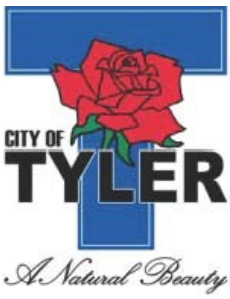
Eligible dependents include the employee's spouse and eligible dependent children up to age 26. This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

3. Employer name	4. Employer Identification Number (EIN)	
City of Tyler	75-6000697	
5. Employer address	6. Employer phone number	
212 North Bonner	903-531-1100	
7. City	8. State	9. ZIP code
Tyler	Texas	75710
10. Who can we contact about employee health coverage at this job?		
Jami Rogers		
11. Phone number (if different from above)	12. Email address	
	jrogers@tylertexas.com	

Special Enrollment Notice: If you are declining enrollment for yourself or your dependents including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below: Phone: 903-531-1112



The information in this benefits guide is intended to help you enroll in your 2021 benefits. Not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern.

The City of Tyler reserves the right to change or terminate benefits at any time. Neither the benefits, nor this enrollment guide, should be interpreted as a guarantee of future benefits.